REQUIRED/MANDATORY

I. MMR: (2) VACCINES REQUIRED

Measles Titer: _____________ (Result and Date)*
Mumps Titer: _____________ (Result and Date)*
Rubella titer: _____________ (Result and Date)*

*Attach Serology Results

II. Varicella: (2) vaccines required

Varicella Titer: _____________ (Result and Date)

OR

Physician documented history of chicken pox or zoster ________________ (Date)

III. Documentation of two-step TST results and date or a negative Quantiferon TB Gold test (QFT-G).

(Attach results)

1. ________________ (Date) 2. ________________ (Date)

☐ Check box if documented history of positive TST. TST is waived and copy of chest x-ray report done.
Date of CXR: ___________________________ Result: ___________________________

☐ Complete TB risk assessment and TB symptom assessment.

TB Risk Assessment
1. Temporary or permanent residence (for ≥ 1 month) in a country with a high TB rate (i.e., any country other than Australia, Canada, New Zealand, the United States, and those in western or northern Europe)  Yes  No

2. Current or planned immnosuppression, including human immunodeficiency virus infection, receipt of and organ transplant, treatment with a TNF-alpha antagonist (e.g., infliximab, etanercept, or other), chronic steroids (equivalent of prednisone ≥ 15 mg/day for ≥ 1 month), or other immunosuppressive medication  Yes  No

3. Close contact with someone who has had infectious TB disease since the last TB test  Yes  No

TB SYMPTOM ASSESSMENT

Persistent fever  Yes  No  Unexplained weight loss  Yes  No
Night sweats  Yes  No  Fatigue  Yes  No
Cough lasting > 3 weeks  Yes  No  Hoarseness  Yes  No
Bloody sputnum  Yes  No  Chest pain  Yes  No

Any other unusual symptoms ____________________________________________

If history positive, were you ever treated?  Yes  No
RECOMMENDED
Td/Tdap Booster: ____________________________ (Date)

Hepatitis B Vaccine:  
#1. ____________________________ (Date)  
#2. ____________________________ (Date)  
#3. ____________________________ (Date)  

Influenza Vaccine: ____________________________ (Date of current season)

REQUIRED
COVID Vaccine #1: ____________________________ (Date)  
#2: ____________________________ (Date)  

COVID Booster ____________________________ (Date)

Name of Healthcare Provider: ____________________________ Date: ____________________________

Signature of Healthcare Provider*: ____________________________ Date: ____________________________

License#: ____________________________

*Required